PREFACE

Effective July 1, 1987, the Idaho Title XIX Program expanded its coverage for inpatient hospital stays. The forty (40) day cap per year per recipient was replaced with an unlimited inpatient stay. All other services and coverages will remain unchanged.

The expansion of coverage prompts a significant change in the reimbursement methodology which impacts provider payments in the future. The current State Plan and Department rules limit inpatient costs by the prior year's Title XIX per admission rate as adjusted for inflation and changes in volume. The proposed amendment will change the methodology to a per diem limit with a fixed base year adjusted annually for inflation.

If the current methodology is maintained, extreme variances in the cost per admission for hospitals are likely to occur. The effect of these extreme costs per admission hampers the efforts for reasonable cost constraints by the State. A provider may be forced to accept drastic reimbursement cutbacks at final settlement far below the actual costs of providing services because of one admission with an extraordinary long or costly stay. Conversely, in the next year, the same provider would not likely experience any costs limitations because of the abnormal cost per admission of the prior year. The proposed plan amendments (See Appendix A) will change the cost per admission to a cost per diem limit that will apply for each day of the patient stay and contain cost increases on a more reasonable basis.

Other changes in the plan will provide adjustments to the cost limit for providers serving a disproportionate share of low income patients, provide for the payment of collection of interest charges on over/under payments to providers at final settlement, treatment of out of state hospital cost settlements and payment rates, and interim payment rate setting.

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ASSURANCES

1. Payment Methodology:

The Idaho Medicaid agency will pay for hospital services through the use of rates that are reasonable and adequate to meet the costs of efficiently and economically operated facilities providing services in conformity with state and federal laws, regulations, and quality and safety standards.

The amendment to the Idaho State Plan is based upon the Medicare retrospective reasonable cost reimbursement principles in effect prior to the Social Security Amendments of 1983. Costs are reported according to the instructions set forth by HCFA for completion of the Cost Report form 2552.

Inpatient hospital payments are based upon a percentage of charges and payments which are cost-settled shortly after the provider's Medicare cost report is finalized by the Intermediary. Because payment is based upon the provider's actual costs, and because reasonable allowable increases in costs are recognized under the amended plan, the Idaho Medicaid agency considers the rates to be reasonable and adequate to meet the reasonable operating costs of a facility providing services to a Title XIX recipient.

The Title XIX cost limit may limit a provider's reimbursable costs determined using Medicare reasonable costs if a provider's Title XIX inpatient aggregate per diem costs increase more than the Hospital Cost Index (HCI). Providers which do not contain costs within the limit of the HCI are considered not to have been operating economically or efficiently. The Title XIX cost limit excludes capital costs and allows for limited adjustments. The Title XIX cost limit affects at least 95% of the payments for inpatient hospital services. Hospitals not affected by the cost limit amendment are governed by the standardized payment rates when cost settlement is determined to be inefficient and uneconomical by the state and the provider. Outpatient services will continue to be reimbursed under Medicare reasonable costs where required.

Payment Rates: Upper Limits

Because costs are reported according to HCFA's Cost Report 2552, and the upper payment limit is defined as the lesser of Medicare or Medicaid reasonable costs, or 100% of the covered inpatient customary charges at final settlement, the proposed rates will pay no more in the aggregate for inpatient hospital services than can be paid under Medicare principles of cost reimbursement. Since cost settlement occurs regularly, the estimated average rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than Medicare.

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The proposed changes in hospital reimbursement recoup overpayments and refunds underpayments to providers. It specifically sets forth response times or appeals and requires the recoupment and refunding of final settlements amounts sixty (60) days after the date of discovery. Interest penalties are also set forth for cost settlements which exceed sixty (60) days.

2. Interim Payment Rates:

The plan amendment provides that adequate rates will be established and assures providers the right of appeal. It does not set forth a specific rate setting methodology. If specific rules were adopted, information other than the best available may not be considered because it would not have been specifically identified and permitted in the rules. The payment rates established will be estimated using the lower of Medicare or Medicaid reasonable costs, or customary charges so that payment rates will be reasonable and adequate and will reasonably pay no more in the aggregate than Medicare would have paid, or Medicaid would have paid up to the cost limit.

a. Using the best information available, the proposed amendment will not result in a significant change in the aggregate provider rates. The average aggregate inpatient rate, weighted to reflect the relative market shares of each provider, would have decreased 2.3% from the state fiscal year 1986 average of 79.22% to approximately 76.9% in state fiscal year 1987. The estimate is slightly low because successful appeals and adjustments will be made. Appendices B, C and D list the current rates, proposed rates, and the differences on individual providers and the aggregate rates.

The rates in Appendix C were calculated using the proposed methodology in an as if rate setting for 1987. The proposed methodology for forecasting interim rates takes into account the plan amendment's proposed cost limit. The formula, as demonstrated in Exhibit 1, is as follows. The allowable per diem operating costs plus capital costs, inflated from the principal year for each routine service area, times the prior year's or the most recent, respective patient day statistics available are used to estimate future cost limit. Charges are estimated using the same patient day statistics multiplied by their respective current accommodation rates on file plus the related ancillary charges inflated by the HCI.

b. As the aforementioned schedules show under this methodology, 14 of 56 providers experienced drops in their rates in excess of ten percent.

The impact of the rate adjustments for decreases in those provider rates for 1987 is insignificant under the plan amendment. The providers with rates below 70% only contribute about 18% of the total inpatient average rate. At the extreme, if each of the providers with the ten lowest rates appealed and received liberal rate increases from 90% to 100% of charges, the overall weighted average rate would increase to 78.2% from 76.9%.

Though there may be an increase because of rate appeals, it will have an insignificant impact because of the uncertainty involved with the rate prediction when forecasting hospital utilization and hospital charge increases. Inpatient payments may typically fluctuate from the average more than 2% or more between fiscal years and from the true ratio of cost to charges at final settlement.

The graphs in Appendixes C and D illustrate the distribution of the changes in the rates on individual providers and the weighted aggregate rate. One-third of the providers will experience small to significant rate decreases while the average weighted rate will remain nearly the same. The distributions display the impact on each provider in relation to their hospital specific rate and the average rate of all hospitals. Both are statistical normal distributions. The weighted average rate only decreased 1.43%, while the straight average decreased only 2.16%.

Long term future payment rates will depend largely on how effectively providers limit the increases in their costs for accommodations and ancillary services and, the extent of rate appeals. It is not feasible to estimate the changes in the payment rates beyond the short run until at least the first years' utilization with unlimited days is available. Increases in operating costs increases will be restrained by the HCI to between 4% to 6% per year through 1989. The plan amendment's methodology will guarantee that the costs of the extended stays will cost no more per day than the cost limit permits or Medicare reasonable cost. To the extent provider's increases in costs exceed the HCI rate, the rates may decrease in the long term because cost per day increases will be limited from the provider's fiscal year end 1984.

Adjustments to the cost limit and a respective adjustment to a provider's interim payment rate may be made for several reasons under rule 03.10455 (Appendix A). If the provider demonstrates an exceptional circumstance similar to a natural disaster or strike existed an appropriate adjustment to the cost limit may be made. If the provider serves a disproportionate share of the low income an adjustment to the limit is provided in accordance with 42 CFR 412.106. The most significant adjustment allows the provider to specifically identify the ancillary costs provided in each inpatient day in the principal year and request that the specific ancillary costs per patient day be used in the per diem caps instead of the prorated ancillary costs in order to prevent an inequitable distribution of ancillary costs in the caps. Each of these adjustments will affect the payment rates.

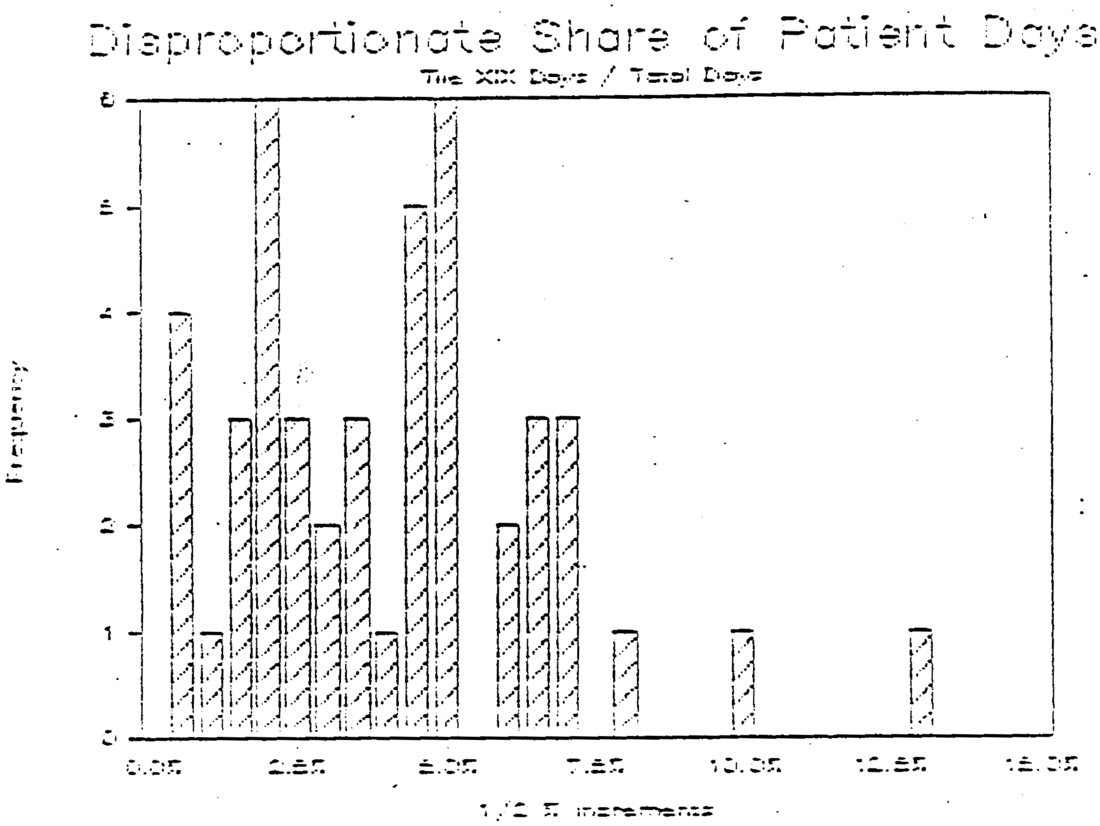
These providers may appeal their rates under the provision for an adjustment to the principal year caps because of the proration of ancillary costs and other exceptions as proposed under rule 03.10455 (Appendix A). As a result, the per diem caps and the rates would be increased under the rate setting

methodology. As always, those rates may change as more timely and reliable information becomes available which minimizes the differences between reimbursable costs and interim payments at final settlement.

3. Disproportionate Share of Low Income Patients:

The plan amendment (Rule 03.10455,02) allows for an adjustment to the Title XIX cost limit. The schedule identified one urban hospital which may qualify for the adjustment for periods beginning after July 1, 1987. Because the data is an estimate based on 1984 statistics in this case, and the provider has not applied and not been approved for such an exception by Medicare or the State, it is 6not likely that the provider will qualify for the exception during the first settlement year the plan amendment becomes effective. An advantage of the plan amendment which follows the expansion of recipient days covered is that all Medicaid eligible days will be documented by the State for a more accurate determination of whether a provider qualifies for this adjustment.

As defined by the criteria provided for in Rule 03.10455,02 which cites 42 CFR 412.106 as its basis, no other urban or rural hospital approaches the limits set forth for a disproportionate share of low income patients.



4. Inappropriate Levels of Care

The State assures the method and payment rates provide reimbursement for hospital patients receiving services at an inappropriate level of care will be made at lower rates consistent with Medicare Law subsection 1861 (v) (1) (G)

The State payment control system includes the following reviews:

a. Each inpatient claim is pre-examined and tested through a series of system edits and audits for reasonable and covered charges, limits on stays, related charges, and the appropriateness of each charge.

b. The system pays no more for accommodations than the daily rate on file multiplied by the reimbursement rate for each level of inpatient care recognized in our system for reimbursement. The state's only swing bed provider is reimbursed under a separate provider number at the swing-bed rate calculated annually.

c. A Surveillance and Utilization Review team reviews hospital claims on an exception basis. They may also monitor providers with exceptional stays or costs.

d. Other hospital claims are reviewed by a staff registered nurse or physician as necessary.

5. Access to Care

Taking into account the geographic locations, and reasonable travel times to adequate quality inpatient hospital services, the State assures that payment rates are adequate to guarantee access to care in any part of any state.

Since the programs inception, no recipient has been denied admission to any hospital or, prematurely discharged, either in Idaho or other states, because of inadequate payment rates.

The following table reflects various statistics from the Medicaid 2082 report to HCFA. A comparison demonstrates that the percent of eligibles using hospital services is remaining reasonably constant while length of stay increases. In 1986 more recipients are using hospital services as the number of eligibles continue to grow. All these points indicate more people are being provided hospital services for increasing severity of illness. Rather than a lack of access, patient care continues to be freely available. Under the extended coverage and the plan amendment, it is expected to see the number of eligibles and the percentage eligible remain reasonably constant. Only the length of stay average and total expenditures may increase significantly since the state already covers the first 40 days of care.

Access to Care Statistics

Per 2082 Report	1983	1984	1985	1986
Discharges	6,398	5,861	6,421	6,152
Unduplicated Users	4,696	4,229	4,477	4,622
Total Eligibles	36,215	36,850	38,850	40,291
Patient Days	33,810	27,398	30,291	31,059
% Eligibles Using	12.0%	11.6%	11.5%	11.5%
Length of Stay	5.7	4.7	4.7	5.1
% Increase in Eligibles	NA	90.2%	106.3%	105.7%
Expenditures	11,824,946	11,570,163	14,290,686	15,623,646
Cost per Discharge	$1,848	$1,974	$2,226	$2,540
Cost per User	$2,518	$2,736	$3,192	$3,380
Cost per Day	$349.64	$422.30	$471.78	$503.05
% Increase Cost / Discharge	NA	106.25%	116.67%	105.98%
% Increase Cost / Day	NA	82.03%	111.72%	106.62%

6. Appeal Process.

Rule 03.10500 set forth the provider's rights to appeal a Department action or inaction on any issue involving payment. These rules guarantee the prompt and considerate review of interim and final payments to providers.

7. Uniform Cost Reports.

Rules 03.10457 -- 03.10459 of the amendment to the plan call for the periodic audit and adequacy of such data required for an audit. The State maintains a common audit agreement with the Idaho Intermediary for Idaho hospitals. Under the Freedom of Information Act the Medicaid agency requests the audited Medicare cost reports from the Intermediaries of Oregon, Washington, Utah, and occasionally Montana. This enables the State to determine payment rates and final settlements from audited uniform annual cost reports with out-of-state providers.

Public Notice.

The State has complied with public notice requirements, and such notice has been published prior to the effective date of the change in the plan. Public notice has been published in every major newspaper which serves participating hospitals in Idaho. Since Boise is the only city with a population of over 50,000, the newspapers serving the greatest geographical region in Idaho were used to guarantee notice to the public. A public hearing was held and thirty (30) days comment period was provided to the public.

The effective date of this change was July 1, 1987 subsequent to its submittal for public notice, hearing and comment.

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9. Forecasted Effects:

The short term effects on the availability of services, types of care furnished, the extent of provider participation, and hospitals serving a disproportionate share of low income patients with special needs is insignificant. No changes are expected.

The impact of rate adjustments for provider rates for the state fiscal year ending in 1988 is insignificant under the plan amendment. The average aggregate inpatient rate would decrease approximately 2.3% on the estimated inpatient expenditures of $20 million dollars, or about $460,000. Even with this reduction in payments, providers are expected to have kept their costs equal to or below the previously established rates.

The long term effect on the above issues is to expect that access to the necessary adequate quality of care will improve, and providers will compete for the Title XIX patients when their cost limits are not exceeded. They will also compete for Title XIX patients in the only urban area of the state, in order to qualify for the disproportionate share adjustment. The types of care will not be influenced by the limits significantly since the cost caps are more sensitive to patient mix than the per admission cap and are applied in the aggregate which provides hospitals with the incentive to provide the level and adequate quality of care.

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ADMINISTRATIVELY NECESSARY DAYS

03.9162 Administratively Necessary Day (AND). An Administratively Necessary Day is intended to allow a hospital time for an orderly transfer or discharge of recipient inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for inpatients who are awaiting placement for SNF/ICF level of care, or in-home services which are not available, or when catastrophic events prevent the scheduled discharge of an inpatient.

01. Limitation of Administratively Necessary Days. Each recipient is limited to no more than three (3) ANDs per discharge. In the event that a skilled or intermediate level of care is required, an AND may be authorized provided that the hospital documents that no SNF or ICF bed is available within twenty-five (25) miles of the hospital.

02. Reimbursement Rates. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho skilled nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/MR rates are excluded from this calculation.

a. The AND reimbursement rate will be calculated by the Department by March 15th of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year.

b. Hospitals with an attached skilled nursing facility will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and,

c. The Department will pay the lesser of the established AND rate or a facility's customary charge to private pay patients for an AND.

03. Reimbursement of Services. Routine services as addressed in Idaho Department of Health and Welfare Rules and Regulations Section 02. a. and b. include all medical care, supplies, and services which are included in the calculation of nursing home property and nonproperty costs as described in Section 4.19d (03.1450 - 03.10999). Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 15 of Attachment 4.19.B.

EXHIBIT I

COSTS:

Type of Day	Cost Caps !	Patient Days @	Estimated Costs
Semi-private	$X	A	A * $X
ICU	$Y	B	B * $Y
Nursery	$Z	C	C * $Z
Others			
Totals			Total Estimated Costs

CHARGES:

	Accommodation Rates	Rate * Days	Ancillary Charges * FYE HCI %
Semi-private	$X1	$X1 * A	Estimated Ancillary Charges
ICU	$Y1	$Y1 * B	
Nursery	$Z1	$Z1 * C	
Others			
Totals		Estimated Routine Charges	

$$\text{Inpatient Rate} = \frac{\text{Total Estimated Costs}}{\text{Total Estimated Charges}}$$

tickmarks:
! -- The cost caps include an estimate of the per diem capital costs as trended forward from the most recent cost report or as appealed and supplied by the provider.

@ -- Patient Days may be from the most recent fiscal year summarized in the State's summary log, or by the patient day statistics supplied by a provider upon appeal. This will help reflect changes in patient acuity an volume mix readily.

NOTE -- Other extraordinary or fully reimbursable costs not included in the operating costs may be added to the costs estimated in the rate if verified.

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